Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Reason Codes and Statements

Updated on 8.15.19

Reason Code	7-element Order
PMD1A	The documentation does not include a 7-element order. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426
PMD1B	The 7-element order includes elements that are illegible. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1D	The 7-element order does not include the beneficiary's name. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1E	The 7-element order contains an incorrect beneficiary's name. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1F	The 7-element order does not include a valid description of the item. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1G	The 7-element order does not include the date of the face-to-face examination. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1H	The 7-element order does not include a valid face-to-face date. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1I	The 7-element order does not include pertinent diagnosis/condition(s) that are directly related to the need for the power mobility device. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1J	The 7-element order does not include the length of need. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1K	The 7-element order does not include the physician/practitioner's signature. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1L	The 7-element order contains a physician/practitioner's signature which does not comply with the CMS signature requirements. Refer to Program Integrity Manual 3.3.2.4 & Local Coverage Article A55426.
PMD1M	The 7-element order does not include the date the physician/practitioner signed the order. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.

PMD1N	The 7-element order contains an invalid physician/practitioner's signature date. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1O	The supplier did not receive a valid copy of the 7-element order within 45 days after the completion of the face-to-face examination. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD1P	The 7-element order is dated prior to the completion of the face-to-face requirements. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD1Q	It is undetermined who completed one or more elements on the 7-element order. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1T	The ordering physician is a Podiatrist (DPM) or Chiropractor (DC). Refer to Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD1U	The 7-element order contains amendments, corrections, and/or delayed entries that do not comply with accepted record keeping principles. Refer to Medicare Program Integrity Manual 3.3.2.5.
PMD1V	The 7-element order does not contain a valid date stamp (or equivalent) to document the receipt date of the order by the supplier. Refer to Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD1W	The 7-element order does not contain a date stamp (or equivalent) to document the receipt date of the order by the supplier. Refer to Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD1X	The 7-element order was not written by the same physician/practitioner who completed the face-to-face examination. Refer to Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD1Z	The 7- element order (explain identified problem with the 7-element order).

Reason Code	General Face to Face Exam/Medical Records
PMD2A	The documentation does not include a face-to-face examination. Refer to 42 Code of Federal Regulations 410.38, Medicare Program Integrity Manual 5.9.2, Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2B	The face-to-face examination does not contain a valid date stamp (or equivalent) to document the receipt date of the examination by the supplier. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2C	The face-to-face examination does not clearly indicate that a major reason for the visit was a mobility evaluation. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2D	The face-to-face examination does not paint a clear picture of the beneficiary's functional abilities and limitations as it does not contain sufficient objective data. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.

PMD2E	Claim history demonstrates the beneficiary received a similar power mobility device within the past five years. The documentation does not demonstrate a change in medical condition that meets the medical necessity for the requested base. Refer to Medicare Benefit Policy Manual 100-02 Chapter 15, Section 110.2.C & Local Coverage Article A55426.
PMD2F	Claim history demonstrates the beneficiary received same or similar durable medical equipment. The documentation does not indicate the rationale for the power mobility device requested. Refer to Medicare Benefit Policy Manual 100-02 Chapter 15, Section 110.2.C & Local Coverage Article A55426.
PMD2H	The medical documentation demonstrates the beneficiary's primary need for the power mobility device is for use outside of the home. Refer to 42 Code of Federal Regulations 410.38 (a), Medicare Program Integrity Manual 5.9.2 & Local Coverage Determination 33789.
PMD2J	The face-to-face examination contains conflicting information. Refer to Local Coverage Determination 33789.
PMD2K	The face-to-face examination was completed on a limited space template with insufficiently detailed or incomplete narrative to support medical necessity from the physician/practitioner. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 3.3.2.1.1.
PMD2N	The supplier did not receive the face-to-face examination within 45 days after the completion date. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2O	The face-to-face examination contains amendments, corrections, and/or delayed entries that do not comply with accepted record keeping principles. Refer to Medicare Program Integrity Manual 3.3.2.5.
PMD2P	The face-to-face examination contains a physician/practitioner's signature which does not comply with the CMS signature requirements. Refer to Program Integrity Manual 3.3.2.4 & Local Coverage Article A55426.
PMD2Q	The face-to-face examination was not signed by the physician/practitioner. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4 & Local Coverage Article A55426.
PMD2R	The 120 days allowed to deliver the power mobility device following completion of the face-to-face examination has been exceeded. Refer to Local Coverage Determination 33789.
PMD2S	The face-to-face documentation is illegible.
PMD2U	The face-to-face examination does not contain a date stamp (or equivalent) to document the receipt date of the examination by the supplier. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2V	The face-to-face documentation does not contain the beneficiary's name. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.

PMD2W	The face-to-face examination does not include the encounter date. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2X	The face-to-face examination is incomplete as it is missing pages. Refer to 42 Code of Federal Regulations 410.38 (c), Local Coverage Determination 33789 & Local Coverage Article A55426.
PMD2Y	The documentation does not demonstrate the beneficiary's power mobility device was lost, stolen or irreparably damaged in a specific incident. Refer to Medicare Benefit Policy Manual 100-02 Chapter 15, Section 110.2.C & Local Coverage Article A55426.
PM2AA	Supplier-produced records, even if signed by the ordering physician/practitioner and attestation letters are deemed not to be part of a medical record for Medicare payment purposes. Refer to Medicare Program Integrity Manual 5.7 & Local Coverage Article A55426.
PM2AB	The addendum to the face-to-face examination was not completed by the treating physician/practitioner. Refer to Medicare Program Integrity Manual 3.3.2.5.
PM2AC	The medical documentation contains conflicting information. Refer to Local Coverage Determination 33789.
PMD2Z	The face-to-face examination (explain identified problem with the face to face)

Reason Code	LCD Criteria Specific
PMD3A	The face-to-face examination does not demonstrate how mobility limitations significantly impair the beneficiary's ability to participate in one or more mobility- related activities of daily living (MRADLs) in the home. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3B	The face-to-face examination does not demonstrate the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3C	The face-to-face examination does not demonstrate the beneficiary's upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3D	The face-to-face examination does not demonstrate the beneficiary is able to safely transfer to and from the power operated vehicle. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3E	The face-to-face examination does not demonstrate the beneficiary is able to operate the tiller steering system of the power operated vehicle. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3F	The face-to-face examination does not demonstrate the beneficiary is able to maintain postural stability and position while operating the power operated vehicle. Refer to Local Coverage Determination 33789.
PMD3G	The face-to-face examination identifies a physical deficit that may prevent the safe use of the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.

PMD3H	The beneficiary's weight does not meet the weight capacity for the power mobility device requested. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3I	The face-to-face examination does not demonstrate the use of the power mobility device will significantly improve the beneficiary's ability to participate in mobility related activities of daily living (MRADLs). Refer to Local Coverage Determination 33789 Policy Article
PMD3J	The face-to-face examination demonstrates the beneficiary expressed an unwillingness to use the power mobility device in the home. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3K	The face-to-face examination does not demonstrate the beneficiary has the mental capability to safely operate the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3L	The face-to-face examination does not demonstrate a caregiver is unable to adequately propel an optimally configured manual wheelchair. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3M	The face to face examination does not demonstrate the caregiver is available, willing and able to safely operate the power mobility device requested. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3N	The face-to-face examination does not demonstrate the use of a power operated vehicle has been excluded. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3S	The documentation does not demonstrate the beneficiary uses a ventilator which is mounted on the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3T	The documentation does not demonstrate the beneficiary's mobility limitations are due to a neurological condition, myopathy, or congenital skeletal deformity. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3U	The documentation does not demonstrate the beneficiary is expected to grow in height. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3V	The documentation does not provide sufficient information to demonstrate why the home does not provide adequate access between rooms, maneuvering space and surfaces for the power operated vehicle. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3W	The documentation does not demonstrate the beneficiary requires a drive control interface other than a hand or chin-operated standard proportional joystick and the system is being used on the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD3X	The documentation does not demonstrate the beneficiary meets the coverage criteria for a power tilt seating system and the system is being used on the power mobility device. Refer to Local Coverage Determination 33789 and Policy Article A52498
PMD3Z	The documentation in the face-to-face examination (explain identified problem with the documentation related to specific criteria in the LCD). Refer to Local Coverage Determination 33789 and Policy Article A52498.

PM3AA	The documentation does not demonstrate the beneficiary meets the coverage criteria for a power tilt and power recline seating system and the system is being used on the power mobility device. Refer to Local Coverage Determination 33789 and Policy Article A52498.
PM3AB	The documentation does not demonstrate the beneficiary meets the coverage criteria for a power recline seating system and the system is being used on the power mobility device. Refer to Local Coverage Determination 33789 and Policy Article A52498.
PM3AC	The documentation demonstrates the beneficiary meets coverage criteria for a skin protection seat or back cushion which is not appropriate with a Captain's Chair. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AD	The documentation demonstrates the beneficiary meets coverage criteria for a positioning seat or back cushion which is not appropriate with a Captain's Chair. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AE	The documentation demonstrates the beneficiary does not have special skin protection or positioning needs to support a sling/solid seat/back wheelchair. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AF	The documentation does not demonstrate the beneficiary's neurological deficits significantly impact the beneficiary's mobility limitations. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AH	The documentation demonstrates the length of need for the power mobility device is less than 3 months and the underlying condition is reversible. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AI	The documentation is not considered timely as it is not dated within the preceding 12 months. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM3AJ	The medical record does not contain the beneficiary's weight. Refer to Local Coverage Determination 33789 Policy Article A52498.

Reason Code	Detailed Product Description
PMD4A	The documentation does not include a detailed product description. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498.
PMD4B	The detailed product description does not include the beneficiary's name.
PMD4C	The detailed product description contains an incorrect beneficiary's name. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426. & Local Coverage Determination 33789 Policy Article A52498
PMD4D	The detailed product description does not include the physician/practitioner's identification information. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498.
PMD4E	The detailed product description contains incorrect physician/practitioner's identification information. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498.

PMD4F	The detailed product description is illegible. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498.
PMD4H	The detailed product description contains insufficient detail to properly identify the item(s) to be dispensed in order to determine they are properly coded. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498.
PMD4I	The detailed product description contains a physician/practitioner's signature which does not comply with the CMS signature requirements. Refer to Program Integrity Manual 3.3.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789, Policy Article A52498.
PMD4J	The detailed product description signature date of the ordering physician/practitioner is incomplete or invalid. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498
PMD4K	The detailed product description does not contain a valid date stamp (or equivalent) documenting the receipt date by the supplier. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498.
PMD4L	The detailed product description is invalid as it was prepared prior to completion of the 7-element order. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498.
PMD4M	The detailed product description contains amendments, corrections, and/or delayed entries that do not comply with accepted record keeping principles. Refer to Medicare Program Integrity Manual 3.3.2.5, Local Coverage Article A55426 & Local Coverage Determination 33789 Policy Article A52498.
PMD4N	The detailed product description contains a Healthcare Common Procedure Coding System (HCPCS) code that is not consistent with the narrative description of the power mobility device as assigned by the Medicare Pricing, Data Analysis, and Coding (PDAC) contractor. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426, & Local Coverage Determination 33789 Policy Article A52498.
PMD4O	The detailed product description contains a power mobility device that has not been coded by the Medicare Pricing, Data Analysis, and Coding (PDAC) contractor at the time of the request. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426, & Local Coverage Determination 33789; Policy Article A52498.
PMD4P	The detailed product description was not signed by the physician/practitioner. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426, & Local Coverage Determination 33789; Policy Article A52498.
PMD4Q	The detailed product description is not dated by the ordering physician/practitioner. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426, & Local Coverage Determination 33789; Policy Article A52498.
PMD4R	The detailed product description does not contain a date stamp (or equivalent) documenting the receipt date by the supplier. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426, & Local Coverage Determination 33789; Policy Article A52498.

PMD4T	The detailed product description is invalid as it was prepared prior to the completion of the face-to-face examination. Refer to Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426, & Local Coverage Determination; 33789 Policy Article A52498.
PMD4U	The detailed product description was signed prior to the amendments, corrections and/or delayed entries to the 7-element order. Refer to Medicare Program Integrity Manual 3.3.2.5, Local Coverage Article A55426, & Local Coverage Determination 33789 Policy Article A52498.
PMD4V	The detailed product description was not completed by the same practitioner who completed the face to face and the 7EO. Refer to 42 Code of Federal Regulations 410.38 (c), Medicare Program Integrity Manual 5.2.4, Local Coverage Article A55426, & Local Coverage Determination 33789; Policy Article A52498.
PMD4Z	The detailed product description (explain identified problem with the DPD)

Reason Code	Supporting Medical Documentation
PMD5A	The supporting medical documentation received was illegible.
PMD5C	The supporting medical documentation does not include a physician/practitioner's signature. Refer to Medicare Program Integrity Manual 3.3.2.4.
PMD5D	The supporting medical documentation contains an illegible signature. Refer to Medicare Program Integrity Manual 3.3.2.4.
PMD5E	The supporting medical documentation contains amendments, corrections, and/or delayed entries that do not comply with accepted record keeping principles. Refer to Medicare Program Integrity Manual 3.3.2.5.
PMD5F	The supporting medical documentation contains a physician/practitioner's signature that does not comply with the CMS signature requirements. Refer to Medicare Program Integrity Manual 3.3.2.4.
PMD5Z	The supporting medical documentation (explain identified problem)

Reason Code	Assistive Technology Professional
PMD6A	The documentation does not demonstrate the supplier's Assistive Technology Professional has a current Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD6B	The documentation does not demonstrate a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certified professional had direct in-person involvement in the selection of the power mobility device. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD6C	The Assistive Technology Professional documentation contains amendments, corrections, and/or delayed entries that do not comply with accepted record keeping principles. Refer to Medicare Program Integrity Manual 3.3.2.5.
PMD6D	The Assistive Technology Professional documentation does not include a signature. Refer to Medicare Program Integrity Manual 3.3.2.4.

PMD6E	The Assistive Technology Professional's Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification has expired. Refer to Local Coverage Determination 33789 Policy Article A52498
PMD6F	The Assistive Technology Professional documentation does not include a date of service. Refer to Local Coverage Determination 33789 Policy Article A52498
PMD6Z	The Assistive Technology Professional documentation (explain identified problem)

Reason Code	LCMP/PT/OT
PMD7A	The financial attestation is not signed by the supplier or licensed/certified medical professional (LCMP). Refer to Local Coverage Determination 33789 Policy Article A52498
PMD7B	The documentation does not include a financial attestation stating the licensed/certified medical professional (LCMP) has no financial relationship with the supplier. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7C	The specialty evaluation completed by the licensed/certified medical professional (LCMP) does not have evidence of concurrence or disagreement by the treating physician/practitioner. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7D	The licensed/certified medical professional (LCMP) mobility examination does not have evidence of concurrence or disagreement by the treating physician/practitioner. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7F	The specialty evaluation by the licensed/certified medical professional (LCMP) contains amendments, corrections, and/or delayed entries that do not comply with accepted record keeping principles. Refer to Medicare Program Integrity Manual 3.3.2.5.
PMD7G	The specialty evaluation is illegible.
PMD7I	The specialty evaluation contains a signature which does not comply with the CMS signature requirements. Refer to Medicare Program Integrity Manual 3.3.2.4.
PMD7J	The financial attestation is not dated. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7K	The financial attestation statement submitted does not contain the name of the licensed/certified medical professional (LCMP) who completed the specialty evaluation. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7L	The financial attestation statement submitted does not contain the name of the licensed/certified medical professional (LCMP) who completed the mobility examination. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7M	The licensed/certified medical professional (LCMP) mobility examination contains amendments, corrections, and/or delayed entries that do not comply with accepted record keeping principles. Refer to Medicare Program Integrity Manual 3.3.2.5.
PMD7N	The licensed/certified medical professional (LCMP) mobility examination is illegible.
PMD7O	The licensed/certified medical professional (LCMP) mobility examination does not comply with the CMS signature requirements. Refer to Medicare Program Integrity Manual 3.3.2.4.

PMD7P	The specialty evaluation was not signed by the licensed/certified medical professional (LCMP). Refer to Local Coverage Determination 33789; Policy Article A52498 & Program Integrity Manual 3.3.2.4
PMD7Q	The licensed/certified medical professional (LCMP) mobility examination was not signed by the LCMP. Refer to Local Coverage Determination 33789; Policy Article A52498 & Program Integrity Manual 3.3.2.4
PMD7R	The specialty evaluation does not contain a date of service. Refer to Local Coverage Determination 33789; Policy Article A52498.
PMD7S	The licensed/certified medical professional (LCMP) mobility examination does not contain a date of service. Refer to Local Coverage Determination 33789; Policy Article A52498.
PMD7T	The specialty evaluation does not include the treating physician/practitioner's signature date. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7U	The licensed/certified medical professional (LCMP) mobility examination does not include the date of concurrence. Refer to Local Coverage Determination 33789 Policy Article A52498.
PMD7V	The specialty evaluation does not contain a valid date stamp (or equivalent) to document the receipt date of the examination by the supplier. Refer to Local Program Integrity Manual 5.9.2, 42 Code of Federal Regulations 410.38 (c) , Local Coverage Article A55426, Coverage Determination 33789 & LCD A55426
PMD7W	The specialty evaluation does not contain a date stamp (or equivalent) to document the receipt date of the examination by the supplier. Refer to Local Program Integrity Manual 5.9.2, 42 Code of Federal Regulations 410.38 (c) , Local Coverage Article A55426, Coverage Determination 33789 & LCD A55426
PMD7X	The specialty evaluation contains conflicting information. Refer to Local Coverage Determination 33789; Policy Article A52498.
PMD7Y	The licensed/certified medical professional (LCMP) mobility examination has been completed on a limited space template with insufficiently detailed or incomplete narrative to support medical necessity from the physician/practitioner. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 3.3.2.1.1.
PMD7Z	The licensed/certified medical professional (LCMP) (explain identified problem)
PM7AA	The specialty evaluation does not document the medical necessity for the power mobility device and its special features. Refer to Local Coverage Determination 33789 Policy Article A52498.
PM7AB	The documentation does not include a specialty evaluation completed by the licensed/certified medical professional (LCMP). Refer to Local Coverage Determination 33789 Policy Article A52498.
PM7AC	The documentation does not include a mobility examination completed by the licensed/certified medical professional (LCMP). Refer to Local Coverage Determination 33789 Policy Article A52498.
PM7AD	The licensed/certified medical professional (LCMP) documentation contains conflicting information. Refer to Local Coverage Determination 33789 Policy Article A52498.

PM7AE	The specialty evaluation has been completed on a limited space template with insufficiently detailed or incomplete narrative to support medical necessity from the physician/practitioner. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 3.3.2.1.1.

Reason Code	Other
PMD8A	An affirmative decision was made on a previously submitted Prior Authorization request for this beneficiary.
PMD8B	No determination letter was sent to the supplier due to insufficient identification information.
PMD8C	No determination letter was sent to the treating physician/practitioner due to insufficient identification information.
PMD8D	No determination letter was sent to the beneficiary due to insufficient identification information.
PMD8Z	The documentation (explain identified problem)

Reason Code	Rejection/Invalid PAR
PMD9A	The beneficiary does not reside in this jurisdiction. Please resubmit your request to Jurisdiction-A at Noridian Healthcare Solutions, Attn: DME-MR PAR, PO BOX 6742, Fargo ND 58108-6742 or fax to 701-277-7891.
PMD9B	The beneficiary does not reside in this jurisdiction. Please resubmit your request to Jurisdiction-B at CGS-DME Medical Review-Prior Authorization, P.O. Box 23110, Nashville, TN 37202-4890 or fax to 615-660-5992.
PMD9C	The beneficiary does not reside in this jurisdiction. Please resubmit your request to Jurisdiction-C at CGS-DME Medical Review-Prior Authorization, P.O. Box 24890, Nashville, TN 37202-4890 or fax to 615-664-5960.
PMD9D	The beneficiary does not reside in this jurisdiction. Please resubmit your request to Jurisdiction-D at Noridian Healthcare Solutions, Attn: DME-MR PAR, PO BOX 6742, Fargo ND 58108-6742 or fax to 701-277-7891.
PMD9H	The documentation does not specify the procedure code of the power mobility device requested, therefore eligibility for Prior Authorization cannot be determined.
PMD9I	The base code of the power mobility device requested is not a code that is eligible for Prior Authorization.
PMD9M	The documentation demonstrates the power mobility device has been delivered and is therefore not eligible for Prior Authorization.
PMD9N	The beneficiary is excluded from Prior Authorization as there is a Representative Payee on file; therefore, claims billed are not subject to the reduction in payment.
PMD9O	This beneficiary is not subject to Prior Authorization due to having a Representative Payee on file; however, the HCPCS code is eligible for Advanced Determination of Medicare Coverage review.
PMD9P	The procedure code is not subject to Prior Authorization; however, it is eligible for Advanced Determination of Medicare Coverage.

PMD9U	A previously affirmative determination has been made on this wheelchair base for this beneficiary.
PMD9Z	The Prior Authorization request (explain identified problem)

Reason Code	Group 2 Pressure Reducing Support Surfaces (PRSS)
SS001	The medical record does not indicate any pressure ulcers on the trunk or pelvis. Refer to Local Coverage Determination 33642 and Policy Article 52490
SS002	The medical record documentation does not indicate the beneficiary has multiple stage II pressure ulcers located on the trunk or pelvis. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS003	The medical record does not demonstrate the beneficiary was on a comprehensive ulcer treatment program for at least a month prior to being placed on a group 2 surface. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS004	Medical record documentation does not demonstrate the staged ulcer(s) have failed to improve over the past month. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS005	The medical record documentation does not demonstrate the beneficiary has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS006	The medical record documentation does not demonstrate the beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS007	The medical record documentation does not demonstrate the beneficiary has been on a group II or III support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS008	The medical record document demonstrates that it has been more than 60 days from the date of the mycocutaneous flap or skin graft surgery, and fails to explain the continued medical need for the specialty mattress. Refer to Local Coverage Determination L33642.
SS009	The order is dated greater than 30 days after the beneficiary was discharged from a hospital or nursing facility. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS010	The medical record documentation indicates that all ulcers on the trunk or pelvis are healed. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS011	The medical record documentation shows ulcer healing has not continued, and does not demonstrate other aspects of the care plan are being modified to promote healing or the use of the group 2 support surface is reasonable and necessary for wound management. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS012	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program. Refer to Local Coverage Determination L33642 and Policy Article A52490.

SS013	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included use of an appropriate group 1 support surface. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS014	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included use of an appropriate group 1 support surface within the past month. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS015	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included regular assessment by a nurse, physician, or other licensed healthcare practitioner within the past month. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS016	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included appropriate turning and positioning within the past month. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS017	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included appropriate wound care within the past month. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS018	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included appropriate management of moisture/incontinence within the past month. Refer to Local Coverage Determination L33642 and Policy Article A52490.
SS019	The medical record documentation does not demonstrate the beneficiary has been on a comprehensive ulcer treatment program which included nutritional assessment and intervention consistent with the overall plan of care within the past month. Refer to Local Coverage Determination L33642 and Policy Article A52490.

Reason Code	**Administrative/Other** *(For Transmission via esMD)*
PMDXA	The file is corrupt and/or cannot be read
PMDXB	The submission was sent to the incorrect review contractor
PMDXC	A virus was found
PMDXD	Other
PMDXE	The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable.
PMDXF	The documentation submitted is incomplete
PMDXG	This submission is an unsolicited response
PMDXH	The documentation submitted cannot be matched to a case/claim
PMDXI	This is a duplicate of a previously submitted transaction
PMDXJ	The date(s) of service on the cover sheet received is missing or invalid.
PMDXK	The NPI on the cover sheet received is missing or invalid.
PMDXL	The state where services were provided is missing or invalid on the cover sheet received.

PMDXM	The Medicare ID on the cover sheet received is missing or invalid.
PMDXN	The billed amount on the cover sheet received is missing or invalid.
PMDXO	The contact phone number on the cover sheet received is missing or invalid.
PMDXP	The Beneficiary name on the cover sheet received is missing or invalid
PMDXQ	The Claim number on the cover sheet received is missing or invalid
PMDXR	The ACN on the coversheet received is missing or invalid